

# YELM FAMILY MEDICINE

## Authorization to Use or Disclose Health Care Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Previous Name: \_\_\_\_\_ SS# \_\_\_\_\_

### I. My Authorization

**You may use or disclose the following health care information (check all that apply)**

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:  
\_\_\_\_\_
- Health care information in my medical record for the date(s): \_\_\_\_\_
- Other (e.g. X-Rays, bills), specify date(s): \_\_\_\_\_

**EXCLUDE the following information from the records released (Please initial):**

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorder/mental health
- Drug and/or alcohol use

#### I request and authorize:

Clinic/Provider Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Ph: \_\_\_\_\_ Fax: \_\_\_\_\_

#### To release my records to:

Yelm Family Medicine  
201 Tahoma Blvd. S.E. Ste. 102  
Yelm, WA 98597  
Ph: 360-458-7761 Fax: 360-458-6612

**Reason(s) for this authorization (check all that apply):**

- At my request
- Attorney request
- Physician request
- Other (specify) \_\_\_\_\_

**This auth. ends:** *(This document does not permit disclosure of health information created more than 90 days after date signed)*

- In 90 days from the date signed
- When the following event occurs: \_\_\_\_\_

### II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment.) However, I do have to sign an authorization form: \* To take part in a research study or to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would affect any actions already taken by Yelm Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

1. Fill out a revocation form (or)
2. Write a letter to Yelm Family Medicine

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (Parent, legal guardian, personal rep.)